Transitions Between Hospital and Home

Early in the Hospital Admission: Collaborate in Hospital with Community Providers to Begin/Update the Coordinated Care Plan

Released September 2016

Patients who have multiple conditions and complex needs may require care across different health care settings (e.g., hospitals, family physicians, etc.), which could potentially pose serious risks to their safety and quality of their care. Incomplete or inaccurate transfer of information, lack of comprehensive follow up care, and/or medication errors at the time of transition could be very dangerous and cause serious, preventable harm to patients. Furthermore, the impact of these risks may be intensified by patients and families who feel unprepared for self-management, and are unsure of how to access appropriate health care providers for follow-up.

Figure 1 is an outline of **innovative practices and evidence-informed best practices** that are designed to improve transitions between hospital and home.

The use of these practices varies significantly across the province. Teams are encouraged to prioritize the implementation of evidence-informed best practices before adoption of the innovative practices outlined in this document. When considering the adoption of innovations, *recommended practices* should be considered first, followed by *promising practices*, and then *emerging practices*.

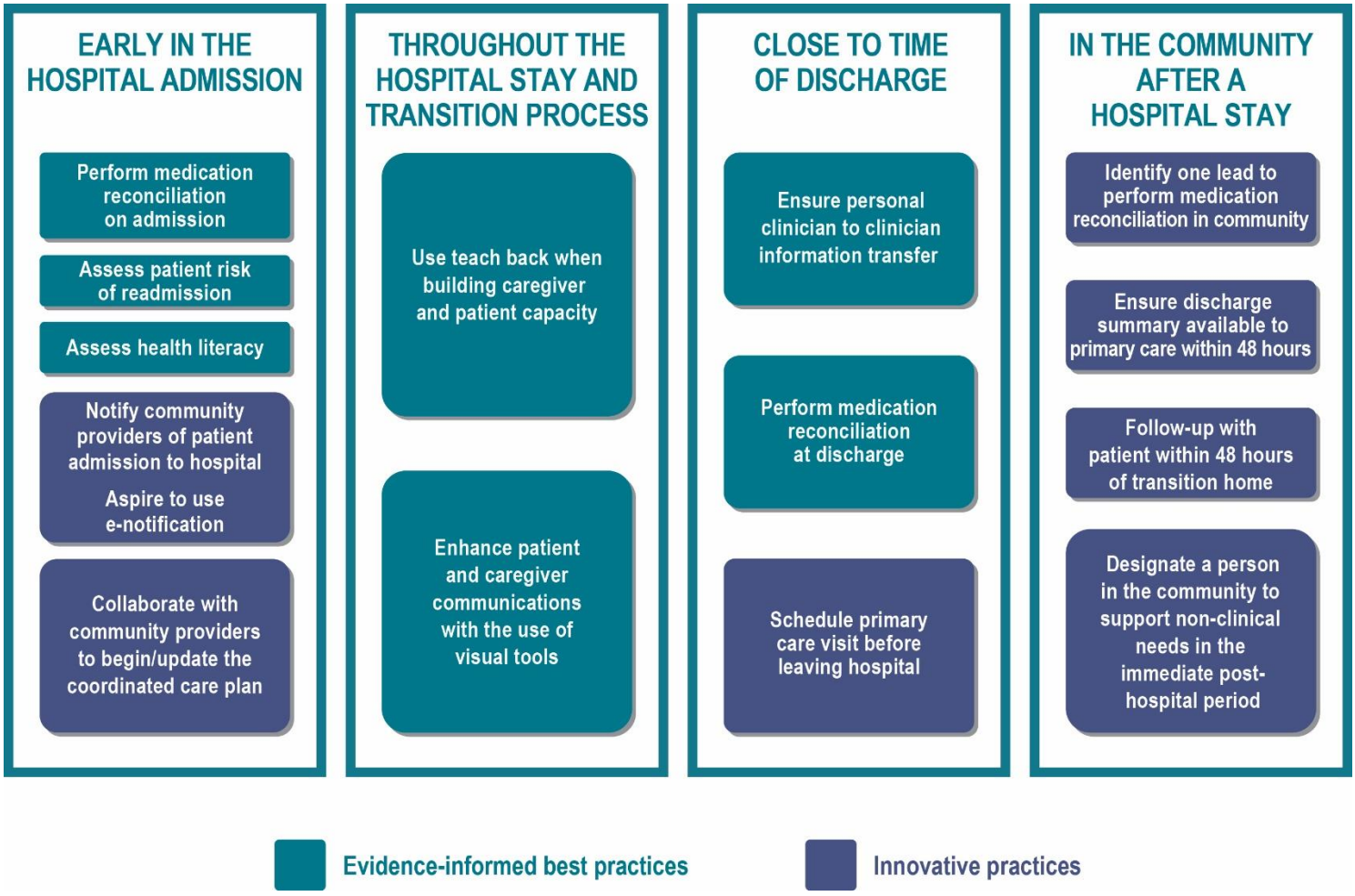

Figure 1: Practices to Improve Transitions Between Hospital and Home

The material for Transitions Between Hospital and Home was developed in collaboration with Health Links and the Clinical Reference Group.

Description of this Innovative Practice

When a patient with complex clinical and social needs enters a hospital, community providers and caregivers should continue to be engaged in planning for the ongoing needs post hospital stay. The Coordinated Care Plan (CCP) should be initiated or updated throughout the hospital stay. Evidence suggests that care planning during transitions can reduce readmissions to hospital. As identified in the Coordinated Care Management innovative practices, the existing single point of contact, regardless of sector, should collaborate in the hospital and post-hospital planning process. There are many points at which hospitals can engage community providers in the planning of a patient's shared care, including at the following stages of the admission process: while the patient is in the emergency department, at daily huddles on the inpatient unit, and during discharge planning meetings.

This innovative practice includes the following actions:

- Encourage the patient and caregiver to provide the name of the provider they feel is their main clinical provider or single point of contact for identified patients with multiple conditions and complex needs.
- Connect with the main clinical provider as early as possible in the care planning process. If there was no prior community main provider, begin by making contact with most logical main community provider based on current circumstances.

Innovative Practice	Innovative Practice Assessment[1]	Clinical Reference Group Endorsement for Spread
Collaborate in hospital with community providers to begin/update the coordinated care plan.	EMERGING	Provincial spread with reassessment using the Innovative Practices Evaluation Framework[1] in one year (September 2017).

Implementation of the Innovative Practice		
Steps for Implementation	**Tools and Resources**	**Considerations**
1. Identify and engage patient at admission Connect with the existing Health Links care team to collaborate with the single point of contact or establish a single point of contact if this is the first connection to Health Links for a patient. The planning with and for the patient should take place as soon as possible upon admission and continue throughout the inpatient admission period. ***2. Leverage existing processes*** The activity of updating the Coordinated Care Plan (CCP) should build upon current hospital and community processes (e.g.,	• **Coordinated Care Management Innovative Practices** on: ○ **"Patients as Partners"** http://www.hqontario.ca/Quality-Improvement/Our-Programs/Health-Links/Coordinated-Care-Management/Interview-Gather-Information-and-Initiate-Coordinated-Care-Plan and ○ **Updating the CCP** http://www.hqontario.ca/Quality-Improvement/Our-Programs/Health-Links/Coordinated-Care-Management/Update-and-Action-Care-Plan • **Central East LHIN Health Links Toolkit:** http://healthcareathome.ca/centraleast/en/who/Documents/Health_Links/toolkit/CEHealthLinks-Toolkit-V2.pdf Examples from the Field: • **Toronto Central LHIN**: The **North East Toronto Health Link** collaborates with **Sunnybrook Health Sciences** Centre to	• Electronic sharing of the CCP helps improve communication between providers. Please see the **Care Coordination Tool**: http://healthcareathome.ca/centraleast/en/who/Documents/Health_Links/toolkit/CEHealthLinks-Toolkit-V2.pdf • This innovation should be implemented in conjunction with **Care Coordination Management Innovative Practices**: http://www.hqontario.c

[1] *For more information about the Innovative Practices Evaluation Framework assessments, please go to the following link: http://www.hqontario.ca/Portals/0/documents/qi/health-links/innovative-practices-evaluation-framework-overview-en.pdf*

Implementation of the Innovative Practice		
Steps for Implementation	**Tools and Resources**	**Considerations**
inpatient huddles, rounds) and be person-to-person interaction (which may be in-person, videoconferencing, or by telephone).	engage complex patients and primary care in coordinated care planning in the emergency department. • **North Simcoe Muskoka LHIN**: At **Collingwood General Marine Hospital (CGMH),** patients are identified as Health Link patients while admitted to CGMH. The hospital connects with the **South Georgian Bay Health Link** to collaborate on current or potential Health Link patients. The Health Link Navigator collaborates with the hospital and follows through with completing the coordinate care plan, involving other collaborative resources in the circle of care.	a/Quality-Improvement/Our-Programs/Health-Links/Coordinated-Care-Management

Measurement

Quality Improvement Measures are used to help with monitoring progress in implementation of a change and determining whether that change is leading to improvement. Just as a health care provider may monitor heart rate or blood pressure to determine a patient's response to treatment, collecting information relating to processes for the improved provision of care allows the team to know whether they are consistently moving towards a high reliability care environment. *For more information on **Quality Improvement and Measurement** please visit* http://qualitycompass.hqontario.ca/portal/getting-started.

The following measures have been developed to help to determine: 1) if Innovative Practices for Transitions Between Hospital and Home are being ***implemented***; and 2) the impact of these practices on Health Links ***processes*** and the ***outcomes*** of care at the patient, population, or systems level.

Health Links, organizations, and/or providers that elect to implement one or more of the Innovative Practices for Transitions Between Hospital and Home are **strongly encouraged to collect data on the associated measures and report them to Health Quality Ontario**. This will enhance analysis at the next review (Sept 2017), which will benefit all of the Health Links.

Suggested Measurements *(please see Appendix A for additional details)*		
Suggested Outcome Measures	**Suggested Process Measures**	**Additional Information**
1. Number of coordinated care plans developed or updated at least once with the patient during hospital admission	2. Percentage of single points of contact (identified prior to hospitalization) that collaborated on updates to the coordinated care plan while patient is in hospital 3. Percentage of patients with multiple conditions and complex needs involved in developing and/or updating their coordinated care plan while in hospital	• Recommend that Health Links collect and report data for a minimum of 3 months. • QI RAP templates will be available if the Health Link chooses to use them. • All patients who are receiving care through the Health Link are included in the sample. • Consider stratifying measures from an equity lens.

References

1. Auerbach AD, Vasilevskis EE, Sehgal N, Lindenauer PK, Metlay JP, Schnipper JL. Preventability and Causes of Readmissions in a National Cohort of General Medicine Patients. JAMA Intern Med. 2016;176(4):484-493.

2. Lawrence K. President's Message: Family Medicine Hospital Care. Can Fam Physician. 2014 Sept;60:857.

3. Naylor MD, Hirschman KB, O'Connor M, Barg R, Pauly MV. Engaging Older Adults in their Transitional Care: What More Needs to be Done? J Comp Eff Res. 2013 Sept;2(5):1-12.

4. Ulin K, Olsson L-E, Wolf A. Person-Centred Care: An Approach That Improves the Discharge Process. Eur J Cardiovasc Nurs. 2016 Apr;15(3):e19-26. [Epub 2015 Feb 3]

Appendix A:
Measurement Specifications for Collaborating in Hospital with Community Providers to Begin/Update the Coordinated Care Plan

Released September 2016

1. Number of coordinated care plans developed or updated at least once with the patient during hospital admission

Stage of Hospital Stay	Early in the hospital admission
Innovative Practice	Collaborate in hospital with community providers to begin/update the Coordinated Care Plan
Type of Measure	Outcome Measure
Definition/Description	This innovative practice includes the following actions: • Encourage the patient and caregiver to provide the name of the provider they feel is their main clinical provider or single point of contact for identified patients with multiple conditions and complex needs. • Connect with the main clinical provider as early as possible in the care planning process. If there was no prior community main provider, begin by making contact with most logical main community provider based on current circumstances. Dimensions: Effective, Efficient, Patient-Centered Direction of Improvement: ↑
Additional Specifications	Calculation Method: Simple count of patients Inclusion Criteria: Patients with multiple conditions and complex needs who have existing coordinated care plans or are identified as needing a new coordinated care plan Exclusion Criteria: Patients who meet the criteria but who are not offered access to the Health Link because they have moved beyond Health Link catchment area, have died, transferred to a different facility or signed out
Reporting Period	Recommend that Health Links collect and report data for a minimum of three (3) months. QI RAP templates will be available if the Health Link chooses to use them.
Data Source	Manual data collection by participating primary care, hospital and community care providers within the Health Link.
Comments	Selected outcome measures will help to evaluate the impact of the efforts to introduce innovative practices into transitions between hospital and home.

2. Percentage of single point of contacts (identified prior to hospitalization) that collaborated on updates to coordinated care plan while patient is in hospital

Stage of Hospital Stay	Early in the hospital admission
Innovative Practice	Collaborate in hospital with community providers to begin/update the coordinated care plan
Type of Measure	Process Measure
Definition/Description	This innovative practice includes the following actions: • Encourage the patient and caregiver to provide the name of the provider they feel is their main clinical provider or single point of contact for identified patients with multiple conditions and complex needs. • Connect with the main clinical provider as early as possible in the care planning process. If there was no prior community main provider, begin by making contact with most logical main community provider based on current circumstances. Dimensions: Effective, Efficient, Patient-Centered Direction of Improvement: ↑
Additional Specifications	Calculation Method: Numerator/Denominator*100 Numerator: Number of single points of contact that collaborated with hospital care team during in-hospital updates to the coordinated care plan Denominator: Number of patients with multiple conditions and complex needs that required updates to their coordinated care plan while in hospital Exclusion Criteria: Patients who did not have an existing coordinated care plan and/or single point of contact prior to admission to hospital
Reporting Period	Recommend that Health Links collect and report data for a minimum of three (3) months. QI RAP templates will be available if the Health Link chooses to use them.
Data Source	Manual data collection by participating primary care, hospital and community care providers within the Health Link.
Comments	The selected process measures are designed to help Health Links draw on the fields of Improvement Science and Implementation Science as these practices are implemented. Process Measures are used to assess: 1. Progress in implementation components such as reach (how often the practice is being used); 2. Adherence (fidelity) to the specifications of the steps that must be in place for a program or practice to operate; and 3. Sustainability of the process as designed so that it will continue once the initial attention has waned.

3. Percentage of patients with multiple conditions and complex needs involved in developing and/or updating their coordinated care plan while in hospital

Stage of Hospital Stay	Early in the hospital admission
Innovative Practice	Collaborate in hospital with community providers to begin/update the coordinated care plan
Type of Measure	Process Measure
Definition/Description	This innovative practice includes the following actions: • Encourage the patient and caregiver to provide the name of the provider they feel is their main clinical provider or single point of contact for identified patients with multiple conditions and complex needs. • Connect with the main clinical provider as early as possible in the care planning process. If there was no prior community main provider, begin by making contact with most logical main community provider based on current circumstances. Dimensions: Effective, Efficient, Patient-Centered Direction of Improvement: ↑
Additional Specifications	Calculation Method: Numerator/Denominator*100 Numerator: Number of patients with multiple conditions and complex needs who report that they "Agree" or "Strongly agree" with the statement *"I was involved in the development and/or update to my coordinated care plan"* Denominator: Number of patients with multiple conditions and complex needs surveyed Exclusion Criteria: Patients who meet the criteria but who are not offered access to the Health Link because they have moved beyond Health Link catchment area, have died, transferred to a different facility or signed out
Reporting Period	Recommend that Health Links complete an audit cycle weekly or monthly. QI RAP templates will be available if the Health Link chooses to use them.
Data Source	Manual data collection by participating primary care, hospital and community care providers within the Health Link.
Comments	The selected process measures are designed to help Health Links draw on the fields of Improvement Science and Implementation Science as these practices are implemented. Process Measures are used to assess: 1. Progress in implementation components such as reach (how often the practice is being used); 2. Adherence (fidelity) to the specifications of the steps that must be in place for a program or practice to operate; 3. Sustainability of the process as designed so that it will continue once the initial attention has waned.